No. 6873

IN THE

United States
Circuit Court of Appeals
FOR THE NINTH CIRCUIT

James McCulloch, Jr.,
Appellant,

vs.

The Penn Mutual Life Insurance Company of Philadelphia, a corporation,
Appellee.

UPON APPEAL FROM THE UNITED STATES DISTRICT COURT FOR THE SOUTHERN DISTRICT OF CALIFORNIA, SOUTHERN DIVISION.

APPELLANT'S OPENING BRIEF

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AUTHORITIES CITED

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Statement

This action was brought for the purpose of securing an adjudication that three policies of life insurance heretofore issued by the defendant and appellee upon the life of plaintiff and appellant were still in force and effect, and for the further purpose of recovering from defendant certain payments which by the terms of said policies were payable to the plaintiff in case of his permanent total disability. A trial was had before the Court without a jury and from a judgment rendered in favor of the defendant for costs plaintiff appeals.

The three insurance policies involved are attached to the answer as Exhibits A, B and C thereto. Exhibit A is a policy for $10,000.00 which was issued October 14, 1925, and appears at pages 48 to 76 of the Transcript. Exhibit B is a policy for $15,000.00 issued November 27, 1925, and appears at pages 77 to 105 of the Transcript. Exhibit C is a policy for $5,000.00 issued November 27, 1925, and appears at pages 106 to 133 of the Transcript.

By the terms of Exhibit A the company agreed to pay a monthly income of $100.00 and waived the payment of subsequent premiums in case the insured became totally and permanently disabled (T. 49). The total annual premium provided for by this policy was $275.60, in which amount there was included a premium of $21.70 for the total and permanent disability benefits (T. 50).

Exhibit B is identical in form and in all particulars except as to amounts. The policy provides for a monthly income of $150.00 and waiver of subsequent premiums in case of total permanent disability (T. 78). Total annual premium provided for in this policy was $413.40, which included a premium of $32.55 for disability benefits. (T. 79.)

The third policy, Exhibit C, for $5,000.00 does not provide for a monthly income in case of disability but provides merely for the waiver of subsequent premiums in case of total permanent disability (T. 107). By its terms an annual premium of $122.50 is provided for which includes a premium of $1.80 for disability benefits (T. 108).

The execution and delivery of these policies is admitted by the answer. It will be necessary in subsequent portions of the brief to analyze in detail the facts surrounding the payment of premiums. It was contended by the plaintiff

that he became totally and permanently disabled about the 31st day of July, 1926, at which time we believe it is beyond controversy that the policies were in full force and effect. We believe that an analysis of the evidence will demonstrate beyond controversy that all three of the policies were in effect up to and including the 18th day of March, 1927, by virtue of payment of premiums made by plaintiff to defendant. Whether these policies continued to be binding and effective by reason of the operation of the disability provisions therein contained is one of the issues to be determined herein.

At the time of the issuance of the $10,000.00 policy, Exhibit A, plaintiff executed and delivered to defendant his note for the premium in the amount of $275.60 (T. 167). It is undisputed in this action that this note was paid, so that it is beyond controversy that the $10,000.00 policy was in force for the first year and the grace period therein provided or at least until November 14, 1926.

In payment of the premiums on the other two policies plaintiff gave to defendant a note for $551.20, dated November 25, 1925. This note was due March 26, 1926 (T. 166). The note was not paid when due but by reason of subsequent transactions between plaintiff and defendant and the giving and paying of a subsequent note we believe that we can demonstrate to the satisfaction of the Court that these policies were in effect, as heretofore stated, until March 18, 1927.

The plaintiff was taken sick on July 31, 1926. He called in Dr. Chester O. Tanner, of San Diego, as his physician. At that time he was confined in bed until about the middle of September (T. 166). Dr. Tanner called into consulta-

tion Dr. W. M. Alberty and Dr. Lyle C. Kinney, of San Diego. Dr. Kinney is a specialist in X-ray diagnosis and took X-ray plates of plaintiff's chest. As a result of examinations and the X-ray diagnosis it was determined at that time that Mr. McCulloch was suffering from tuberculosis and had at the time tubercular pneumonia. The X-ray plates showed "tuberculosis throughout both lungs with fluid at the base of the right lung." (T. 181.) Although the nature of plaintiff's illness was determined at the time, the doctors did not tell Mr. McCulloch of the nature of his illness. He was given to understand that he was suffering from pneumonia and pleurisy with effusions, and it was not until July, 1927, that he learned of the nature of his illness (T. 166, 169 and 170).

At the time the plaintiff was taken ill he was engaged in business as manager of a hospital in San Diego, although he was not a physician or surgeon (T. 176). The evidence is undisputed that plaintiff remained in bed until some time in September, 1926, and was confined to his house until about the first part of November of that year (T. 176). During the balance of the year he was in a very weak condition but made a few short trips to his hospital in an attempt to keep in touch with his business. He testified that he went to the hospital once or twice in November, eight or ten times in December and about the same number of times in January (T. 179, 180). He was unable to look after his business and has been unable to transact any business since July, 1926. His business went from bad to worse and failed and was placed in bankruptcy in March, 1927 (T. 166, 180). Plaintiff's testimony with respect to his illness and disability was corroborated in every respect

by the testimony of his wife, Mrs. Anna R. McCulloch. During the early part of 1927 plaintiff was not confined to his bed, but with the exception of short trips of an hour or so to the hospital he was confined to his home. In April, 1927, he was again confined to his bed, where he stayed for about a month (T. 214). Mrs. McCulloch learned in August, 1926, that the plaintiff was suffering from tuberculosis but did not tell him the nature of his illness and corroborates his statement that no one else told him (T. 213). During this period of time Mrs. McCulloch knew nothing about the insurance policies in question (T. 214). As a result she did not appreciate the necessity of conveying this information to her husband in so far as it affected the insurance policies.

Referring again to the $10,000.00 policy, the note given in payment of the first year's premium was paid in part on December 12, 1925, and the balance due was paid on September 10, 1926 (T. 165). In November, 1926, a note was given by the plaintiff for the second year's premium on the $10,000.00 policy (T. 167). After being confined by his illness, with the resultant failure of his business, Mr. McCulloch was unable to pay this note when due. However this policy did not enter into the subsequent transaction, between him and the agent for the company, in February, 1927, at which time Mr. McCulloch was endeavoring to keep his insurance under policies No. 1196774 and No. 1196773 (Exhibits B and C) in force. A postdated check for $300.00 and an additional note was given by him to the agent (T. 167), but he was unable to deposit available funds to meet the check. The check was placed in the hands of the District Attorney and prosecution was threatened. As a final result Mr. McCulloch surrendered the policies to the

agent for the defendant and a note for $339.39, dated April 19, 1927, payable to defendant's agent, was executed. (T. 169.) This note, as we will endeavor to show, covered the term insurance and disability premiums up to and including March 18, 1927.

Plaintiff was unable to do any work during the early part of 1927, although at that time he believed that he had recovered from his illness and would eventually regain his health. However, in April, 1927, he was again confined to his bed. The first direct information to the plaintiff that he was suffering from tuberculosis was from Dr. Pasche of San Diego on July 6, 1927, when plaintiff made application to the Veterans' Bureau for hospitalization (T. 169). Shortly thereafter plaintiff made application to the Metropolitan and to the Acacia Insurance Companies, in which companies he carried other insurance, for allowance of disability benefits as provided in those policies. The application to the Metropolitan Life Isurance Company appears at pages 195 to 203 of the Transcript, and that to the Acacia Mutual Life Association at pages 204 to 211. In both of these applications the plaintiff's disability was stated to have commenced in April, 1927, when he was again confined to his bed.

The evidence, as we will more fully point out, amply establishes that from July, 1926, when plaintiff was first stricken, up to and including the time of trial, plaintiff was totally disabled by reason of tuberculosis, with little, if any, indication that he would ever recover. Although his application for disability benefits by the other two insurance companies were allowed in 1927, plaintiff made no effort to collect from the defendant or to enforce his rights arising

from the disability provisions contained in the policies sued upon until 1929, at which time demand was made upon him for the payment of the note for $339.39 to which reference has been made. Plaintiff's response to the demand was that he failed to see why he should be compelled to pay for this insurance from which he got no benefit whatever. Upon being informed that the company claimed that he had received the benefit of this insurance, he asked for copies of the three policies and upon receipt of them made demand for his disability benefits, which demand was refused (T. 170). In the face of this situation defendant's agent compelled the plaintiff to pay the note (T. 169, 175). As a result of these transactions plaintiff commenced action upon the policies.

Plaintiff's contention has been throughout that he became totally and permanently disabled, as those terms are used in the insurance policies, during the last part of July, 1926, at a time when all three policies were in force, and that by the terms of the policies the defendant company agreed to waive all future premiums and to pay him additional sums aggregating $250.00 per month upon the two policies for $10,000.00 and $15,000.00. Appellant contends further that he had no knowledge of the nature of the disease from which he was suffering or of the fact that his disability was permanent in character until July, 1927, and that the transactions in the early part of 1927 in which the policies were surrendered were without consideration and were entered into under a misapprehension and mistake of fact. He contends further that he should be relieved from his failure to notify the company of the existence of his permanent disability by reason of the fact that he was in ignorance of the character of his illness and therefore it was impossible for

him to give such notice, and that his delay in making claim for the disability has involved no detriment to the company and is excusable because he had no copies of the insurance policies and believed that the entire subject had been dropped and that he had no protection by reason of the issuance of the policies until he learned that the agent for the company was insisting upon his payment therefor.

The case was tried by the Court without a jury and judgment rendered in favor of the defendant for costs. The findings of the trial Court are throughout adverse to plaintiff's contentions. The entire decision, however, may be said to center around the finding of the trial Court to the effect that plaintiff was not permanently disabled in 1926, during the time the policies were admittedly in force, but that such disability dated from April 9, 1927, when plaintiff was again confined to his bed. Plaintiff contends that this finding is contrary to the undisputed evidence and finds support in no substantial evidence offered by the defendant. We contend further that other adverse findings, predicated as they are upon the finding just mentioned, necessarily fall with it. We believe that we can demonstrate to the satisfaction of the Court that the law amply supports the position of the plaintiff that he is entitled to a recovery and to a new trial of this cause upon showing that his disability arose in 1926 and has existed continuously thereafter.

POINTS AND AUTHORITIES

I

The Three Policies Sued Upon were in Full Force and Effect in July and August, 1926, at the Time the Plaintiff Became Disabled.

II

The Facts Proven at the Trial Establish that the Plaintiff Became Totally and Permanently Disabled During the Time the Policies were in Force.

7 Couch on Insurance, 5783.

American Liability Company v. Bowman, 65 Ind. App. 109, 114 N. E. 992.

Turner v. Fidelity and Casualty Company, 112 Mich. 425, 70 N. W. 898, 38 L. R. A. 529.

Lobdill v. Laboring Men's Mutual Aid Association, 69 Minn. 14, 71 N. W. 696, 38 L. R. A. 537.

James v. United States Casualty Company, 113 Mo. App. 622, 88 S. W. 125.

Hagman v. Equitable Life Assurance Society, 282 S. W. 1112, 214 Ky. 56.

Mutual Benefit Association v. Nancarrow, 71 Pac. 423, 18 Colo. App. 274.

Pacific Mutual Life Insurance Company v. Branham, 70 N. E. 174, 34 Ind. App. 243.

North American Accident Insurance Company v. Miller (Tex.), 193 S. W. 750.

United States Casualty Company v. Perryman, 82 So. 462, 203 Ala. 212.

Great Eastern Casualty Company v. Robins, 164 S. W. 750, 111 Ark. 607.

Fidelity and Casualty Company of New York v. Logan, 229 S. W. 104, 191 Ky. 92.

Taylor v. Southern States Life Insurance Company, 106 S. C. 356, 91 S. E. 326, L. R. A. 1917 C 910.

Jones v. Fidelity and Casualty Company of New York, 207 N. W. 179, 166 Minn. 100.

Metropolitan Life Insurance Company v. Bovello, 12 Fed. (2d) 810, 56 App. D. C. 275, 51 A. L. R. 1040.

Jacobs v. Loyal Protective Insurance Company, 124 Atl. 848, 97 Vt. 516.

Heralds of Liberty v. Jones, 142 Miss. 735, 107 So. 519.

III

The Requirement that Insured Give Notice of Disability Before a Default in Premium is Excused by Insured's Ignorance of the Permanence of His Disability.

Wick v. Western Union Life Insurance Company, 104 Wash. 129, 175 Pac. 953.

Minnesota Mutual Life Insurance Company v. Marshall (C. C. A. 8), 29 Fed. (2d) 977.

Stipcich v. Metropolitan Life Insurance Co., 277 U. S. 311, 48 S. Ct. 512, 72 L. Ed. 895.

McMaster v. New York Life Ins. Co., 183 U. S. 25, 22 S. Ct. 10, 46 L. Ed. 64.

Bergholm v. Peoria Life Insurance Company, 76 L. Ed. 306.

Southern Life Insurance Company v. Hazard, 148 Ky. 465, 146 S. W. 1107.

Merchants' Life Insurance Company v. Clark (Tex. Civ. App.), 256 S. W. 969.

Missouri State Life Insurance Company v. Le Fevre (Tex. Civ. App.) 10 S. W. (2d) 267.

Meropolitan Life Insurance Company v. Carroll (Ky.), 273 S. W. 54.

Fidelity Mutual Life Insurance Company v. Gardner's Administrator, 233 Ky. 88, 25 S. W. (2d) 69.

Bank of Commerce and Trust Company v. North-

western National Life Insurance Company (Tenn.) 26 S. W. (2d) 135.

Mid-Continent Life Insurance Company v. Hubbard (Tex.), 32 S. W. (2d) 701.

Intersouthern Life Insurance Company v. Hughes' Committee, 6 S. W. (2d) 447, 224 Ky. 405.

Levan v. Metropolitan Life Insurance Company, 138 S. C. 253, 136 S. E. 304.

McColgan v. New York Life Insurance Company, 36 Ohio App. 123, 172 N. E. 849.

State Life Insurance Company v. Fann (Tex.), 269 S. W. 1111.

Hagman v. Equitable Life Assurance Society, 214 Ky. 56, 282 S. W. 1112.

Aetna Life Insurance Company v. Palmer, 159 Ga. 371, 125 S. E. 829.

Hawthorne v. Travelers' Protective Association, 112 Kan. 356, 210 Pac. 1086, 29 A. L. R. 494.

Newman v. John Hancock Mutual Life Insurance Company, 216 Mo. App. 180, 7 S. W. (2nd) 1015.

Inter-Southern Life Insurance Company v. Duff, 184 Ky. 227, 211 S. W. 738.

Security Life Insurance Company v. Gottman (Ind. App.), 156 N. E. 173.

Spencer v. Security Benefit Association (Mo. App.), 297 S. W. 989.

Frommelt v. Travelers' Insurance Company, 150 Minn. 66, 184 N. W. 565.

Shafer v. United States Casualty Company, 156 Pac. 861, 90 Wash. 687.

Houseman v. Home Insurance Company, 88 S. E. 1048, 78 W. Va. 203, L. R. A. 1917-A 299.

IV

The Attempted Cancellation and Surrender of the Policies was Ineffectual.

Argument

At the outset permit us to make our contentions plain. We believe that the record demonstrates that the three insurance policies sued upon were in full force and effect during 1926. If plaintiff became totally and permanently disabled during that period, the liability of the defendant arose under the disability provisions contained in the policies. Plaintiff's disability was one of the risks insured against and if this risk occurred at a time when the policies were admittedly in force, there was no consideration whatever for the surrender of the policies and such surrender was made under a misapprehension of existing facts. If, on the other hand, plaintiff's disability did not arise until April, 1927, after the policies had been surrendered, then defendant would not be liable, as the liability under the disability provisions would attach only in case the insurance was then in force.

It is only fair, therefore, that we concede at the outset that if the plaintiff was not totally and permanently disabled in 1926, as shown by the evidence offered on his behalf, he cannot recover. We must concede, of course, the full force of the rule that findings of fact of the lower Court, if based upon conflicting evidence, will not be disturbed upon appeal, even though the Appellate Court might feel that it would have made a different decision had it passed upon the issue of fact in the first instance. But it is equally well settled that before an Appellate Court will sustain a finding of fact attacked as contrary to the evidence upon the theory that it

is based upon a conflict of testimony, there must be a substantial conflict. There must be evidence of a substantial nature in support of the finding so made. It is obvious that unless we can demonstrate that there is no substantial conflict in the evidence for the Court's finding that plaintiff did not become totally and permanently disabled until April, 1927, then the judgment must be affirmed. If, on the contrary, we are able to demonstrate to the satisfaction of the Court that there is no substantial dispute or conflict in the testimony, and that plaintiff's evidence demonstrates beyond controversy that he was disabled in 1926, as claimed, then it follows that the judgment must be reversed, as the entire fabric of the Court's findings is built around the proposition that plaintiff failed to establish his disability as of the alleged date and at a time when the insurance was in effect.

There is ample authority for the proposition that the provisions of insurance policies requiring the giving of notice of such disability are not effective to defeat the liability to pay upon the happening of the risk insured against, where by reason of ignorance of the facts, it is impossible for the insured to give such notice. It follows therefrom that the failure to give notice at the time of the happening of the disability must necessarily be excused, and that the purported cancellation and surrender of the policies became ineffective by reason of mistake of fact and failure of consideration.

I

The Three Policies Sued Upon were in Full Force and Effect in July and August, 1926, at the Time the Plaintiff Became Disabled.

Inasmuch as there was some considerable controversy at the trial as to the length of time plaintiff was insured by these three policies, it is of considerable importance that this feature of the case be set at rest at the outset. It is of small importance, perhaps, to determine the exact day upon which the insurance terminated unless extended by the disability provisions. We are perfectly willing to concede that unless the insurance was so extended, it ceased to become effective after March 18, 1927, and before plaintiff was again confined to his bed. Considerable testimony was introduced relative to the purported surrender of these policies, but the uncertainty in this regard is of relatively little importance when it is once established that the insurance was actually effective at the time plaintiff's disability arose.

Little need be said relative to the policy for $10,000.00, copy of which is attached to the answer as Exhibit A. As heretofore pointed out, at the time this policy was taken out, a note for $275.60 was given by plaintiff to defendant. This note was paid in instalments, $150.00 being paid in December, 1925, and the balance paid by check dated September 10, 1926 (T. 165). It may be taken as beyond controversy, therefore, that this policy was in effect at least the first year, plus the additional period of grace, or until November 14, 1925.

Considerable uncertainty arose, however, as to the other two policies, both of which were issued as of November 27, 1925. A note for $551.20 was given by plaintiff to defendant in payment of the first year's premium for these two policies. It was not paid when due but was extended over a period of time. The first year of the three policies, including the grace period, elapsed. Various notes were

given for the second year's premiums on the same policies. On December 30, 1926, plaintiff signed note surrender policies, purporting to surrender the $15,000.00 and $5,000.00 policies in return for the cancelation of his notes, which instruments appear at pages 188 and 189 of the Transcript. It became apparent, however, that in so far as these instruments purport to recite a mutual release between the company and the plaintiff, they are entirely misleading and incorrect in that there was no release of liability to the plaintiff, nor any intention to so release him. On the contrary, the entire gist of the transaction was a cancelation of the various policies, but in such transaction plaintiff was charged for insurance up to and including March 18, 1927. An instrument in similar form was on March 18, 1927, executed with reference to the $10,000.00 policy (T. 187). In February, 1927, in an effort to reinstate his insurance and continue it in force, plaintiff executed and delivered a postdated check payable to the order of C. L. Randolph and Son, agents for the defendant. Failing to meet this check, it was delivered over to the District Attorney's office and the plaintiff was threatened with prosecution (T. 168). Plaintiff's contention that he was summoned to the District Attorney's office and confronted with the check is corroborated by the testimony of John D. Cornell, County Detective attached to the District Attorney's office, who was called on behalf of defendant (T. 223, 224). A letter sent to Mr. McCulloch in March, 1927, contains a direct threat of prosecution (T. 224). As a result of this situation all of the policies were taken up, surrendered as of date of March 18, 1927, and note for $339.39, payable to Mr. Don C. Carrell, one of the company's agents, was executed. This

note was dated April 19, 1927, and was for sixty days (T. 169).

At the time of the trial plaintiff was uncertain as to the manner in which the amount in question was determined. Mr. Charles L. Randolph, one of the company's agents, made some attempt to explain the amount of the note, but his testimony was equally indefinite (T. 226, 227). He attempted to claim that of this amount $233.40 was for term insurance and that the balance was for some personal obligation, the nature of which he did not know, being a transaction between Carrell and the plaintiff (T. 228). Fortunately, however, by simple arithmetical computation the matter can be readily explained. Mr. Randolph in his testimony recited:

> "The term charge was charged back to the agent. The term charge is the actual charge for insurance for death only. It provides no other, no commission. No waiver of premium for disability or commission." (T. 227.)

It was the insistence of Mr. Randolph that the amount charged in this note contained no charge for disability benefits that created a situation of some uncertainty. Mr. Randolph was unable to tell what the term charge was and seemed utterly at a loss to explain the figures. It is unnecessary to go out of the record for a conclusive explanation, however, for the terms of the policies themselves make the situation entirely clear. The plaintiff contends that at the time of the execution of this note the gist of the transaction was the surrender of the policies and that he was charged for insurance under all of them up until the time of their surrender March 18, 1927.

Turning to the terms of the policies themselves, particular attention is called to Section 3, which is the same in all policies. By way of illustration we take that from the $10,000.00 policy, Exhibit A, appearing at pages 54 and 55 of the Transcript. This section deals with policy values and "non-forfeiture in event of lapse." Three options are provided for and reference is made to the loan or cash surrender values of the policies and an option given for a term of automatically extended insurance without participation. In substance, it is provided that at the end of the third year the policy shall have a loan or cash surrender value of $35.17 per thousand, or a value of $351.70 for the $10,000.00 policy. Option No. 2 provides for the purchase of paid up *life insurance* (T. 54). Under the disability provisions of the policy it is provided that these benefits shall terminate "if this policy be surrendered for its cash value, or if any paid-up or extended insurance provided for in Section 3 of this policy becomes effective." (T. 58.) It therefore becomes apparent that the figures given in the table in Section 3 of the policy refer only to the life insurance feature of the policy and not to the disability provisions, and that therefore the amount of extended insurance provided for therein has reference to life insurance alone, not coupled with any permanent disability provision.

It makes no difference how the company arrives at the amount of $35.17 as the loan or cash surrender value per thousand, as that is a matter of contract and includes the amount of cash reserve set aside on each policy. It is to be noted, however, that the same amount per thousand is provided in each policy. If the policy has been kept in force for three years, it has a loan or cash surrender value of this fixed amount. It is provided, however, that instead of

taking the cash surrender value, the assured is given the option of permitting such amount to be applied to the purchase of a term of automatically extended insurance without participation for a period of four years and seventy-two days. It is common knowledge that this provision is nothing more than a recital of the fact that $35.17 is the net cost per thousand of term insurance for the period mentioned. If, therefore, $35.17 will purchase $1,000.00 of term insurance for four years and seventy-two days, it is a matter of simple arithmetical computation to figure the term rate of such insurance. The time provided is equivalent to 1,532 days, which divided into $35.17 gives an amount of $.022956 per day, or a term rate of $8.38 per thousand per year. This would make a term rate of $125.70 per year on the $15,000.00 policy and $41.90 on the $5,000.00 policy. From November 27, 1926, the last day of the first year's term of these policies, is 112 days, which at the term rate would call for $39.00 on the $15,000.00 policy and for $13.00 on the $5,000.00 policy. From October 14, 1926, to March 18, 1927, is 156 days. The first year's term on the $10,000.00 policy expired on October 14, 1926, and prorating the term insurance upon that policy for the period mentioned would call for $35.80.

As pointed out heretofore, no term rate is provided for the disability benefits. By the terms of the $15,000.00 policy it is provided that the disability double indemnity and waiver of premium shall be paid for at the rate of $51.30 per year. In the $10,000.00 policy the premium for such benefits is $34.20 per year. The premium for the disability benefits in the $5,000.00 policy, which does not include the payment of monthly benefit, is $1.80 per year. There being no provision for term insurance for these benefits upon a

surrender of the policy, these benefits would be prorated. Based upon the computations made in the manner just mentioned, we produce the following table of calculations:

POLICY NUMBER 1196774 for $15,000.00

Net term life insurance for one year at $8.38 per thousand ending November 27th, 1926	$125.70	
Disability, double indemnity and waiver of premium one year ending November 27th, 1926	51.30	
Net term life insurance for 112 days from November 27th, 1926, to March 18th, 1927, inclusive, at $8.38 per thousand per year	39.00	
Disability, double indemnity and waiver of premium 112 days from November 27th, 1926, to March 18th, 1927, inclusive, at $51.30 per annum	15.73	$231.73

POLICY NUMBER 1196773 for $5,000.00

Net term life insurance for one year at $8.38 per thousand ending November 27th, 1926	$ 41.90	
Disability, waiver of premium benefits one year ending November 27, 1926	1.80	
Net term life insurance for 112 days from November 27th, 1926 to March 18th, 1927, inclusive, at $8.38 per thousand per annum	13.00	
Disability waiver of premium benefits for 112 days from November 27th, 1926, to March 18th, 1927, at $1.80 per annum	.56	$ 57.26

POLICY NUMBER 1191014 FOR $10,000.00

Net term life insurance for 156 days from October 14th, 1926, to March 18th, 1927, inclusive, at $8.38 per thousand per annum	$ 35.80	
Disability, double indemnity and waiver of premium 112 days from October 14th, 1926, to March 18th, 1927, inclusive, at $34.20 per annum	14.60	$ 50.40
Total		$339.39

Obviously, therefore, there can be little doubt of what went into the note for $339.39. It is interesting to note that apparently the theory was that upon the surrender of these policies, the term rate should be applied to the insurance. However, there was no attempt to apply the term rate to the $10,000.00 policy, the first year's premium upon which had been fully paid to the company. Had the three policies been treated in the same manner, Mr. McCulloch would have been entitled to a large credit upon this amount by reason of paying the full premium for the first year on the $10,000.00 policy. In any event, it is obvious that the intention of the parties was that he should pay for the insurance protection supposed to have been accorded to him upon the three policies up to and including March 18, 1927.

There need be no uncertainty in the minds of the Court by reason of the fact that Mr. McCulloch was not charged the full premium on the other two policies for this period of time. It is common knowledge that term insurance may always be bought at a much cheaper rate than insurance which can be renewed by the yearly payment of premium

throughout the life of the insured. If a man is twenty-five years old and takes out a policy which he can maintain throughout his life, an average premium is determined which is much more than the rate which would be charged for a limited period of an insured of that age, as the figures are based upon his expectancy of life. Where, however, a company undertakes to insure only for a limited term and obviates the necessity of presuming that the insurance will cover the insured throughout his life, a much cheaper rate can properly be charged. Here, therefore, when the parties undertook to surrender the policies and terminate the company's liability, there was no necessity of charging more than the term rate for life insurance. We submit that this calculation demonstrates to a mathematical certainty that the insurance was considered by the contracts of the parties as being in effect, including all disability benefits, to and including March 18, 1927. As a matter of fact, the exact date is of small moment except for the purpose of demonstrating that these three policies of insurance, coupled with all disability benefits, were effective and in full force at the time of plaintiff's alleged disability. It is interesting to note that Mr. Carrell, the agent, exacted the execution of this note from the plaintiff upon the theory that the amount named had been paid to the company and plaintiff was compelled to pay the note. The defendant having been paid for this insurance, it should be required to respond in case it be shown that one of the risks insured against occurred during the life of the policy.

II

The Facts Proven at the Trial Establish that the Plaintiff Became Totally and Permanently Disabled During the Time the Policies were in Force.

It is the appellant's position that the undisputed evidence established that he became totally and permanently disabled on the last day of July, 1926. It is true that the Court has found that such disability did not arise until April, 1927. In presenting this feature of the case we are entirely mindful of the rule that the Appellate Court will not disturb the findings of fact of the lower Court, based upon a conflict of evidence. It is also the rule, however, that there is no conflict of evidence where the evidence in support of the Court's finding is not of a substantial nature. There must be a real conflict in the testimony before the presumptions in favor of the trial Court's findings apply. Where, as here, the evidence clearly establishes the existence of the disability, a contrary finding, unsupported by any substantial evidence, is ineffectual.

It is beyond dispute that McCulloch was taken seriously ill on the last of July, 1926; that Dr. Tanner and Dr. Alberty were called; that Dr. Lyle C. Kinney was called in his expert capacity to make X-ray diagnosis; and that these three doctors concurred in the diagonsis that the plaintiff was suffering from pulmonary tuberculosis. It remains undisputed that McCulloch was confined to his bed until the middle of September, 1926; that he has never recovered from the disease, has never been able to work since and upon frequent occasions since that time he has been again confined to his bed. The fact that McCulloch today and at the time of the trial was totally disabled from following a gainful occupation is beyond controversy. The testimony of Dr. Tanner is positive to the effect that the appellant was suffering from tuberculosis, but that he did not tell McCulloch of that fact (T. 181). Dr. Alberty testified positively that McCulloch was suffering from tuberculosis in August,

1926; that he was totally disabled and had been totally disabled ever since that time (T. 183). The Doctor further testifies that McCulloch at the time of the trial was still disabled, but that McCulloch was not told the nature of his disability in 1926 (T. 184). Dr. Lyle C. Kinney, who made the X-ray examination, diagnosed appellant's ailment as fibroid tuberculosis (T. 215). He states that the plaintiff was totally disabled with the disease (T. 216). His express findings to that effect are set forth on page 217 of the Transcript. This evidence is completely corroborated by the testimony of Mrs. McCulloch, who describes in detail the plaintiff's condition (T. 213, 214), and who testifies that she knew nothing concerning the policies, and that Mr. McCulloch was not advised as to the nature of his disability until July 6th, 1927 (T. 215).

In so far as it was possible, therefore, the plaintiff presented to the Court positive, expert testimony supported by scientific diagnosis. This evidence remains undisputed. No testimony was offered, disputing the diagnosis of these physicians, nor disputing the facts relative to the plaintiff's condition. Let us view, therefore, those things introduced on behalf of the defendant upon which the trial Court predicated his finding that the plaintiff was not disabled in 1926.

It appears that in the early part of 1927, as heretofore pointed out, the plaintiff, still ignorant of the nature of his physical disability and still believing that his illness was pleurisy, was attempting to keep these policies in force and to bring about their reinstatement. In that connection he gave to the agents of the defendant an application for reinstatement of the $5,000 and $15,000 policies, appearing at page 191 of the Transcript. In this application the following statements were made:

"Are you in good health? Yes."
(T. 192.)

And also:

"Lobar pneumonia, July, 1926—
2 mo. disability, complete recovery.
No complications. Dr. C. O. Tanner,
1st Natl. Bank Bldg., San Diego, Calif."

At that time he was examined by Dr. Herbert S. Anderton, who testified that he thought the plaintiff had completely recovered from his former illness and that he made no clinical findings of tuberculosis (T. 218). Dr. Anderton's testimony, however, failed utterly to withstand the test of cross-examination. He testified that although he saw no indication of active tuberculosis, he had no X-ray findings or other proper examination to determine this question (T. 219). He also testified that the examination given the plaintiff at that time was an ordinary life insurance examination, no other examination being made (T. 220). In response to questions asked by the Court Dr. Anderton admitted, after examining the X-ray plates taken of the plaintiff in August, 1926, that there was no essential difference between his reading of the X-ray plates and that of Dr. Kinney, who testified on behalf of the plaintiff (T. 222). In the face of these admissions made by Dr. Anderton upon cross-examination, his testimony amounts to nothing and furnishes no substantial dispute or contradiction of the evidence offered on behalf of the plaintiff.

The defendant called Mrs. Louise Barnett, who had been a nurse in the hospital owned by McCulloch, apparently in an endeavor to prove that in the early part of 1927 the plain-

tiff was conducting his business. However, the witness refused to so testify, stating in substance that the plaintiff appeared at the hospital on occasion and stayed there only for short periods of time (T. 225).

We submit that the statements contained in the application for reinstatement of the policies, to which reference has been made, furnish no substantial evidence whatever. When examined concerning this application, the plaintiff stated in substance that at the time it was made he did not know the nature of his illness, he thought he had been suffering from pleurisy and thought that he was on the road to recovery. He believed that he was in a convalescent state and stated that when the examination was made he thought he was in good health (T. 190). It must be recollected that although plaintiff was operating the hospital and was manager of the business, he was not a physician or surgeon (T. 176). He had no more expert knowledge to apply to his condition than any other layman. For reasons best known to his wife and the doctors, the true nature of his illness had not been reported to him. It is common knowledge that people suffering from this dread disease are prone to take a very optimistic view of their condition and apparently have little or no realization of the gravity of the ailment. There is not a syllable of testimony to indicate that McCulloch actually knew that he was affected with tuberculosis. His statement to Dr. Anderton, the insurance examiner, therefore, does no more than corroborate plaintiff's contention that he was then ignorant of the fact that the disability from which he was suffering was total and permanent. Such statement or admission proves nothing further.

It is only fair that in considering this feature of the case the Court take into consideration the entire surrounding circumstances. As we have pointed out, McCulloch, by reason of his illness, was unable to attend to his business. It is undisputed that he was pressed financially and was having extreme difficulty in meeting his obligations. He was making every effort to keep his insurance alive. His hospital business was finally terminated by an adjudication in bankruptcy. Yet during the time that he was confined to his bed, desperately ill with tuberculosis, he had in his hands these three insurance policies, by the express terms of which all future premiums were waived in case of his disability. They also contained the provision requiring the company to pay to McCulloch the monthly income of $250.00 upon furnishing proof of disability. Can the Court conceive of any possible reason for plaintiff's failure to make this claim at that time except the one obvious reason that he did not know the nature of the disability from which he was suffering?

It has been frequently held that the disability contemplated by contractual provisions of this nature is such disability as prevents the insured from following his ordinary business or gainful occupation. It is not contemplated by the parties that the disability must be so extensive that a man can move neither hand nor foot, for it is seldom that one is so completely disabled. The phrase is construed in its popular sense as meaning such disability as prevents the insured from earning his livelihood as he has theretofore done.

The general rule is laid down in *7 Couch on Insurance,* 5783, as follows:

"As to the test for determination of what constitutes total permanent disability, it has been said that, since every case must depend upon its own facts, there can be formulated no general rule more definite than that relativity and circumstances control; and that every insured's rights depend upon the consequences of his own impairment and disability, and not upon whether his capacity be less or more than that of the average man. A good-faith, though ineffectual, effort to perform the duties of one's usual employment does not preclude a finding of total and continuous disability preventing the performance of every duty pertaining to such employment, even though the insured succeeded in properly performing a part of his former duties, if he might reasonably have refrained from doing any work. And one afflicted with 'Buerger's disease,' or 'thrombo augititis obliteraus,' a progressive and incurable disease of the veins and arteries which leads to closure of the arteries of the extremities to such an extent that the sufferer requires constant care and about eight hours' treatment daily, is 'totally and permanently disabled,' although he could, with some discomfort and possible danger, follow some occupations for a few hours a day."

An interesting case is *American Liability Company v. Bowman*, 65 Ind. App. 109, 114 N. E. 992. The policy provided that insured should receive a monthly payment for the period "that the assured is totally and continuously from the date of accident disabled and prevented from performing every duty pertaining to any business or occupation." It appeared that after an injury received for a period of something more than a month the insured actually went to his

office daily and for such period actually performed a part of his duties, although with considerable pain and discomfort. A finding that he was totally disabled, within the meaning of the policy, during all of such time was upheld by the Court. The Court said:

> "Where a party is shown to be in fact totally disabled for the entire period for which compensation is sought, it cannot be held as a matter of law that he was not disabled because during a portion of such time he made a good faith, though ineffectual, effort to perform the duties of his usual employment." (Page 995.)

Two interesting cases are reported in Vol. 38 L. R. A.; *Turner v. Fidelity and Casualty Company,* 112 Mich. 425, 70 N. W. 898, 38 L. R. A. 529, and *Lobdill v. Laboring Men's Mutual Aid Association,* 69 Minn. 14, 71 N. W. 696, 38 L. R. A. 537. In the first case it was held that the fact that a man goes to his office every day for a short time, without doing any work or business there, does not show that he is not wholly disabled from prosecuting any and every kind of business pertaining to his occupation. A similar rule was laid down in the second case, in which it was held that total disability does not mean absolute physical inability to transact any kind of business, and that ability to occasionally perform some trivial or unimportant act connected with some kind of business pertaining to the assured's occupation did not render his disability partial instead of total, provided he was unable to substantially or to some material extent transact any kind of business pertaining to such occupation.

In *James v. United States Casualty Company,* 113 Mo. App. 622, 88 S. W. 125, the assured was a merchant. After

receipt of an injury by falling from a street car, he spent several days in bed and thereafter went to his place of business almost daily, where he signed checks, approved orders for goods and dictated letters. However, he could not do many of the principal duties pertaining to his business. A finding that he was totally disabled was upheld.. It was contended that before a man could be held to be totally disabled, he must be in condition where he could not perform any part of any of the duties of his business. The Court said:

> "It cannot be that the parties intended that before an assured could recover on the policy he should lie the full period of his injury in a state of coma. To interpret the clause in its contractual sense, as defendant seeks to have us do, would render the contract utterly useless to an assured, and would have been nothing short, practically speaking, of collecting a premium without rendering a consideration."

In *Hagman v. Equitable Life Assurance Society,* 282 S. W. 1112, 214 Ky. 56, the Court held that the plaintiff was physically incapacitated, within the meaning of a life insurance policy containing provisions very similar to those involved in the case at bar, during the period he was suffering from a broken leg, although in the meantime his wife drove him to the office in an automobile, where he was able to sit at a desk and, although suffering intensely, could answer the telephone and direct, to a certain extent, his business.

In *Mutual Benefit Association v. Nancarrow,* 71 Pac. 423, 18 Colo. App. 274, it was held that:

> "The words 'totally disabled' as used in an accident policy, do not mean a state of absolute helplessness.

> The insured might be able to walk, might be able to ride on the cars to his physician's office, and still have been entirely incapacitated for work or business. If he is so incapacitated, we think he is totally disabled, within the meaning of the policy."

A similar ruling was laid down in *Pacific Mutual Life Insurance Company v. Branham,* 70 N. E. 174, 34 Ind. App. 243, in which it was held that it was sufficient to prove that the injury wholly disabled the assured from doing of all substantial and material acts necessary to be done in the prosecution of his business, or that his injuries were of such a character and degree that common care and prudence required him to desist from his labors so long as was necessary to effect a speedy cure.

In *North American Accident Insurance Company v. Miller* (Tex.), 193 S. W. 750, it was held that total disability consisted of such disability as would require the insured to desist from the transaction of his business, in the exercise of ordinary care in the preservation of his life and health.

In *United States Casualty Company v. Perryman,* 82 So. 462, 203 Ala. 212, it was held that total disability might exist under a policy defining the same as inability "to perform any and every business duty or occupation," although it was physically possible for insured to perform occasional acts as part of his employment or business, it being unnecessary that insured be confined to his room, home or hospital for the entire period for which he claims total disability.

In *Great Eastern Casualty Company v. Robins,* 164 S. W. 750, 111 Ark., 607, the insured was held to be totally dis-

abled, though he was able to go to his office a few times to give instructions to his foreman.

In *Fidelity and Casualty Company of New York v. Logan,* 229 S. W. 104, 191 Ky. 92, the assured was a lawyer, who devoted much of his time to caring for timber and mining interests. After his injury he could do only about one-third of his usual work and the evidence showed that care and prudence required him to desist from transacting any business. It was held by the Court that he was totally disabled.

Disease rendering a man unfit to carry on a gainful occupation was held to constitute total disability in *Taylor v. Southern States Life Insurance Company,* 106 S. C. 356, 91 S. E. 326, L. R. A. 1917C 910.

It has been repeatedly held that in order to establish total disability it is unnecessary to prove absolute physical disability.

Jones v. Fidelity and Casualty Company of New York, 207 N. W. 179, 166 Minn. 100;.

Metropolitan Life Insurance Company v. Bovello, 12 Fed. (2d) 810, 56 App. D. C. 275, 51 A. L. R. 1040;

Jacobs v. Loyal Protective Insurance Company, 124 Atl. 848, 97 Vt. 516.

In many of the cases which we will cite in the subsequent division of our argument illness is treated as total disability, within the meaning of the provisions of policies similar to those involved in this action. It would seem as a matter of common judgment that there could be no more generally recognized total disability than an active pul-

monary tuberculosis. The few times that the plaintiff went to his office for periods of approximately an hour proved nothing more than an earnest endeavor on his part to carry on his business as best he could. The gist of his contract was an insurance against a disability depriving the plaintiff of his earning power, and we respectfully submit that the disability proven is that and more.

The further provisions of the policies are in accord with this construction, for it is provided in Section 4 that in case of a recovery from disability, the disability benefits shall cease and the company is given the privilege to require from time to time additional proof of the continuance of the disability. It is also provided in that section that "after said total disability has been continuous for not less than three consecutive months immediately preceding the receipt of due proof, such disability, if not already approved as permanent, shall nevertheless be deemed to be permanent." By such provision of the policy the company has bound itself to a construction that a so-called "permanent" disability exists by reason of illness or injury, even though a man may recover or may not be totally incapacitated for the balance of his life.

It has been held that by such a provision a disability extending for the required period raises a conclusive presumption that the man is totally permanently disabled. *Heralds of Liberty v. Jones,* 142 Miss. 735, 107 So. 519.

We respectfully submit that in accordance with the rules laid down in the foregoing authorities the plaintiff was totally and permanently disabled and that there is no substantial conflict in the evidence to support the finding of the trial Court to the contrary.

III

The Requirement that Insured Give Notice of Disability Before a Default in Premium is Excused by Insured's Ignorance of the Permanence of His Disability.

Numerous exceptions have been taken to the findings of the trial Court. It is unnecessary to discuss these findings separately and in detail. All of the Court's findings center around and are predicated upon the finding that the insured was not disabled during the period that the policies were in force. We are forced to concede that if this finding is supported by the evidence, this case is at an end, for it is obvious that the plaintiff would not be entitled to recover unless the risk insured against occurred while the policies were in good standing. When we have once established, however, as we submit we have, that the undisputed evidence establishes the total permanent disability of the plaintiff, occurring at a time when all policies were admittedly in force, the case presents an entirely different aspect. It is utterly beyond controversy that the plaintiff did not know of the nature of his disability until July, 1927, after the policies had been surrendered. It must be borne in mind that the disability benefits are not merely an incident to the insurance contracts, but for a certain definite premium the defendant has insured against the risk of total permanent disability in addition to its provision for life insurance. If, therefore, the risk insured against occurred, a liability arose. It is true, of course, that the insurer has the right to insert in its policies proper and reasonable provisions for the giving of notice of the occurrence of the risk and for the giving of such notice while the policy is in force. Such provisions, however, are obviously inserted for the sole purpose of providing that the insured act with reasonable

promptitude in giving notice of loss or occurrence of the risk in order that the insurer may make prompt investigation, but it is not the policy of the courts to permit such provisions to be so construed that they furnish to the insurer an opportunity to escape its contractual liability when the failure to give prompt notice is occasioned by facts without the control of the insured. For example, fire insurance is written upon a house. It is entirely proper that the insurer insert provisions for giving prompt notice of loss, but the giving of such notice is obviously excused when it can be shown that the insured did not know of the fire which destroyed the building. So here the plaintiff is excused from giving notice of the existence of a permanent disability when it is conclusively shown that he did not know the nature of his ailment. It is shown beyond dispute that he thought that his illness was of such nature as constituted only a temporary disability, which would not give rise to a right of recovery under the policies.

We conceive this to be the principal question of law involved in this action. Quoting from Policy A for $10,000.00, the policy reads:

> "The company agrees to pay a monthly income of $100.00 and waive payment of subsequent premiums upon receipt of due proof that the insured has become totally and permanently disabled before the policy anniversary on which the age of the insured at nearest birthday is sixty years, as provided in section four."

In Section 4 appears the following language:

> "If the insured shall become totally and permanently disabled before the policy anniversary on which the age of the insured at nearest birthday is sixty years, the

company will pay to the insured a monthly income equal to one per cent. of the face amount of this policy (exclusive of any dividend additions). Said income shall start upon the date of receipt by the company at its Home Office during the insured's lifetime of due proof of total and permanent disability and continue thereafter for the period of said total disability of the insured prior to the maturity of this policy. * * * *

"The company will waive the payment of any premium falling due after receipt of due proof of total and permanent disability and during the continuance of said total disability of the insured. * * * *

"Disability shall be total and permanent if the insured is, upon the receipt of due proof, totally and permanently prevented by bodily injury or disease from engaging in any occupation whatever for remuneration or profit and became so disabled while this policy was in force by payment of premium. Immediately upon receipt of due proof of such total and permanent disability, the benefits shall become effective, subject to the conditions herein provided. If said total disability has been continuous for not less than three consecutive months immediately preceding the receipt of due proof, such disability, if not already approved as permanent, shall nevertheless be deemed to be permanent and upon the receipt of due proof of such disability the benefits shall become effective, subject to the conditions herein provided."

The language of the $15,000.00 policy is, of course, identical. The language of the $5,000.00 policy is the same

except that it provides only for the waiver of premium, using the following language:

> "If the insured shall become totally and permanently disabled before the policy anniversary on which the age of the insured at nearest birthday is sixty years, the company will waive the payment of any premium falling due after receipt by the company at its Home Office during the insured's lifetime of due proof of total and permanent disability and will continue to waive payment of premiums for the period of said total disability of the insured prior to the maturity of this policy."

The definition of total and permanent disability and provision for continuance of disability for three months are identical with that quoted from the other policy. Provisions of this nature are of comparatively recent origin and there are not many cases in which they have been construed. There is, however, a rather sharp conflict of authority in construction of this type of provision. It will be noted that the policy provides that proof of the existence of a permanent total disability shall be given to the company while the policy is in force. The question naturally arises whether the insured may be excused from giving notice of this character and in case of a failure to give proof of the disability prior to default in payment of premium, these provisions are effective. There is a line of decisions to which the appellee will call the Court's attention, adhering to a very strict construction of this language.

Such, for example, is *Wick v. Western Union Life Insurance Company,* 104 Wash. 129, 175 Pac. 953. In that case the Court, construing similar language in a policy, holds, in substance, that there is no contract to pay disa-

bility benefits except in the situation where proof of disability is given prior to default in payment of premium, and that therefore claim for disability benefits made after default in payment comes too late.

We believe, however, that the better reasoned cases and the weight of authority is to the contrary. In the final analysis the peril insured against is a total permanent disability. The man purchasing insurance is given to understand that in case of his disability he shall receive a monthly income and in addition thereto his life insurance will be kept in force without the payment of additional premiums. For this protection he pays a certain definite portion of the aggregate premium. Admitting, of course, that provisions requiring notice of the occurrence of the peril insured against are reasonable and in ordinary cases should be enforced for the protection of the company, yet provisions of this nature are incidental and not an integral part of the original contract of insurance. Provisions in a policy for the payment of premium and other provisions constituting conditions precedent to the coverage are on an entirely different basis. For instance, take the "iron safe clause" occurring in fire insurance policies, where in substance the company agrees to insure provided premium is paid and the insured keeps certain records of his business in an iron safe. Such provisions go to the very contract of insurance and constitute conditions precedent.

Turning again, however, to provisions such as here involved, the company agrees that the insured shall receive the benefit of certain "disability benefits," provided he becomes disabled while the policy is in force. If he has paid his premium and if he becomes totally permanently dis-

abled, the occurrence of the risk entitles him to the benefits. Proof of disability is provided for just as proofs of loss are required in other types of insurance. Yet the substance of the contract is that as soon as the company receives notice of the disability, the insured shall be entitled to his benefits. This type of provision differs somewhat from the ordinary provision inserted in accident policies which require notice of the happening of the accident within a certain numbers of days. In this type of provision, instead of requiring notice within any given time, the company provides merely that it will not pay until it receives the proof. The gist of its contract, however, is to pay the benefits in case of the happening of the contingency. It is our position that such provision does not make time the essence of the giving of the notice, and that if the insured can show a reasonable excuse for failing to give notice promptly, then he is entitled to receive his benefits, provided he can prove that the risk or peril insured against has actually occurred.

Suppose, for instance, while the policy is in force the insured is injured and is rendered unconscious or in such physical condition that it is impossible for him to give notice. It seems unbelievable that his policy could be canceled for non-payment of premium while he remained in that condition. So also he must be excused when he shows that he was ignorant of the fact that he was permanently disabled. If the insured holding this type of policy lost both of his legs, there would be little excuse for his failure to notify the company prior to default in the payment of premium. It must be recollected, however, that the peril insured against in this instance is not illness or mere temporary disability. No benefit is allowed by this insurance

for such disability. The disability insured against must be permanent. True, the plaintiff in this action knew that he was sick, but he did not know that his illness was of a permanent character which rendered him totally and permanently disabled. Upon the happening of that contingency there could be no default in the payment of premium for the obvious reason that no further premium could become due during the continuance of the disability. Notice of any kind to the company would have required that the company waive all further premiums and pay to the insured an aggregate of $250.00 per month during the period of disability.

We do not find a California decision in point. We do find, however, that the Federal Court has taken an unequivocal stand in its interpretation of this type of provision. In *Minnesota Mutual Life Insurance Company v. Marshall* (C. C. A., 8), 29 Fed. (2d) 977, the policy involved provided that if the insured, while the policy is in full force and effect and without default in the payment of premium "shall become totally and permanently disabled, as hereinafter provided, and shall furnish satisfactory proof thereof, the company will waive the payment of premiums thereafter becoming due. * * * * Second: Upon the receipt of due proof of total and permanent disabilities as above defined, the company will waive the payment of all premiums thereafter becoming due." It is of passing interest, though of no importance, that the policy in question was written on October 14, 1925,—the same date as borne by the $10,000.00 policy in the instant case. Prior to the end of the first year the insured became ill. During the period of his illness the second annual premium became due and was unpaid. His illness continued and he was operated on

for appendicitis shortly after the expiration of the grace period, and about two weeks later he died. The Court said:

> "On the question of when the time of waiver of the payment of premiums begins under policy provisions similar to these quoted, there are two lines of decisions; one holding that proof of disability fixes the time when the waiver begins; and the other holding that the time of waiver is the time of disability, and that a reasonable time thereafter is allowed to make proof of such disability, and that if death occurs before the proof of disability is made, although after the due date of the premium, the insurance company is liable, where the disability arises before the due date of the premium, and continues until death.
>
> "It is unnecessary to attempt to distinguish the language of the policies upon which these differing opinions are based. They unquestionably put a different construction upon practically the same provisions of insurance policies. They differ as to the construction of the same or similar language. These decisions of themselves establish doubt as to the construction and meaning of the provisions which we are called upon to interpret. It is a familiar rule of construction that where contracts of insurance are prepared by the insurer and there is doubt as to the meaning of their provisions, it will be construed most favorably to the insured.
>
> " 'It is said that compliance with this provision, even though impossible, was a condition precedent to the securing of insurance. But narrow and unreasonable interpretations of clauses in an insurance policy are

not favored. They are prepared by the insurer and if, with equal reason, open to two constructions, that most favorable to the insured will be adopted.' *Josephine Stipcich v. Metropolitan Life Insurance Co.*, 277 U. S. 311, 48 S. Ct. 512, 72 L. Ed. 895.

"Forfeitures are not favored: 'The rule is that if policies of insurance contain inconsistent provisions or are so framed as to be fairly open to construction, that view should be adopted, if possible, which will sustain rather than forfeit the contract.' *McMaster v. New York Life Ins. Co.*, 183 U. S. 25, 22 S. Ct. 10, 46 L. Ed. 64.

"However much the legal mind may differ as to the meaning of these provisions, the ordinary layman would construe them to mean that, in the event he became disabled before his premium fell due, his insurance would be continued until his disability was removed or until his death. That is the natural and reasonable construction to be placed upon the language used in this policy. Any other construction to my mind, would be contrary to the full purpose of the contract and deprive the insured of one of the principal benefits of his policy. The right of the insured to have his premiums discontinued during disability is one that he had paid for. To make its operation depend upon the time of proof of disability, and not upon the time of disability itself, which was the real thing that he was protecting himself against, renders the provision of the policy under construction inoperative and the right of no value.

"If the insured had died during the grace period of

his policy, without the payment of the premium which fell due October 14th, no question would be raised as to the right of his beneficiary to recover. Why should a different rule be applied when a disability during the grace period is sustained which renders him totally and permanently disabled? To give the insured the full benefit of his policy, and carry out the intention which was doubtless in the minds of the contracting parties when the policy was written, his policy should not be allowed to forfeit where his disability occurs during the grace period of his policy and continues until his death. Any other construction would be a harsh one and deprive him of a right for which he had paid the insurance company, and which he could only enjoy by employing in advance some agent to protect for him. Why so construe this disability clause in insurance policies as to make it worthless in many cases? Death benefits are good for thirteen months, and are fixed as of the date of death. Why should not the disability benefits be good for the same length of time, and begin as of the date of the disability? This is not an unreasonable and strained construction, and would be more in keeping, perhaps, with the representations made at the time of writing the insurance policy. The same measure of protection should be extended to the insured during the thirteenth month that he admittedly has during the other twelve months.

"Courts taking a different view have unconsciously, in my opinion, been influenced by the belief that the insured did not, if he had lived, intend to continue the insurance. But this should not in any way determine the construction to be placed upon these doubtful provi-

sions, for the right to protection in case of disability has been paid for for the same length of time allowed in case of death. So long as the insured was in good standing, and he became disabled, under the provisions of his policy he had a right to protection.

"A construction making the disability benefits to begin as of the time of proof might be all right, where such benefits are sought while the insured is living, but a disability provision such as the one to be construed here, where the disability occurs near the due date of the premium and continues until death, is made worthless by holding the proof of disability and not the disability itself makes it operative. Such a construction is harsh and unreasonable and ought not to be adopted if the language used is susceptible of one more favorable to the insured. *Southern Insurance Co. v. Hazard*, 148 Ky. 465, 146 S. W. 1107; *Merchants' Life Insurance Co. v. Clark* (Tex. Civ. App.) 256 S. W. 969."

Just what the Court had in mind by the dictum relative to the collection of benefits during the lifetime of the assured is difficult to state. Probably the Court referred to decisions rendered upon accident policies. We believe, however, that other decisions which we will refer to will demonstrate that there is no difference in the status of the provisions for the waiver of premiums and the provisions for the payment of total disability. It will be noted that the language of the policies is the same with reference to both types of "disability benefits," and that the $5,000.00 policy refers to the waiver of premium in the same language.

Since the trial of this case the United States Supreme Court has handed down its decision in *Bergholm v. Peoria*

Life Insurance Company, 76 L. Ed. 306, in which recovery of disability benefits was denied because of the fact that no application was made while the policy was in force, and it is entirely possible that the respondent may seek some comfort from this decision. It is to be noted, however, that although the Supreme Court granted certiorari because of a supposed conflict with the decision in *Minnesota Mutual Life Insurance Company v. Marshall, supra*, upon further consideration that opinion is not disturbed. It is to be noted that in the Bergholm case no equitable excuse was offered for a failure to give the notice required by the terms of the policy. It is to be noted further that the language contained in the policies sued upon in this action is more nearly similar to that contained in the Marshall case than that set forth in the Bergholm case. The Marshall case stands, therefore, as authority for the proposition urged upon this appeal.

In the foregoing decision the Court cites with approval two cases. The first is *Southern Life Insurance Company v. Hazard*, 148 Ky. 465, 146 S. W. 1107. In this case the policy was issued September 27, 1909, and an annual premium paid. The insured became totally and permanently disabled on June 25, 1910, which disability continued until the time of his death on May 8, 1911. In the meantime there was a default in the payment of premium. The policy provided:

> "Premiums on this contract will be paid by the company if insured is wholly disabled. After one full annual payment shall have been made, and before a default in the payment of any subsequent premium, the insured shall furnish satisfactory proof that he is

been wholly disabled by bodily injuries or disease * * * the company * * * will agree to pay for the insured the premiums, if any, which shall thereafter become payable during the continuance of such disability."

In a well considered opinion the Court held that the disability having occurred, the insurance might be collected by his estate despite the fact that no proof of disability was given the company. Among other things, the Court said:

"In the case at bar Hazard's right to have the company pay his premiums was fixed, under the terms of the policy, at the time he became disabled, on June 25, 1910. He was not required to pay anything to have that right perfected, since by the terms of the policy all he had to do was to furnish proof of his disability. The right, therefore, having been fixed during the life of the policy, and without the payment of any further premiums, it is apparent, under the authority of the Montgomery Case, and the other cases heretofore cited, that time was not of the essence of Hazard's right to have the company pay his premiums. The presumption naturally arises that, having become totally disabled physically, he was not in a condition to attend to his business with that promptness which is required of persons in a normal condition. It is such conditions as these that give rise to the doctrine that time is not, in equity, of the essence of the contract. Since Hazard had the right at the time he became disabled, for the mere asking, to have the company pay his premiums until his death, we see no reason why, under the authorities heretofore cited, that he should not have had a reasonable time thereafter in which to present the

Life Insurance Company, 76 L. Ed. 306, in which recovery of disability benefits was denied because of the fact that no application was made while the policy was in force, and it is entirely possible that the respondent may seek some comfort from this decision. It is to be noted, however, that although the Supreme Court granted certiorari because of a supposed conflict with the decision in *Minnesota Mutual Life Insurance Company v. Marshall, supra,* upon further consideration that opinion is not disturbed. It is to be noted that in the Bergholm case no equitable excuse was offered for a failure to give the notice required by the terms of the policy. It is to be noted further that the language contained in the policies sued upon in this action is more nearly similar to that contained in the Marshall case than that set forth in the Bergholm case. The Marshall case stands, therefore, as authority for the proposition urged upon this appeal.

In the foregoing decision the Court cites with approval two cases. The first is *Southern Life Insurance Company v. Hazard,* 148 Ky. 465, 146 S. W. 1107. In this case the policy was issued September 27, 1909, and an annual premium paid. The insured became totally and permanently disabled on June 25, 1910, which disability continued until the time of his death on May 8, 1911. In the meantime there was a default in the payment of premium. The policy provided:

> "Premiums on this contract will be paid by the company if insured is wholly disabled. After one full annual payment shall have been made, and before a default in the payment of any subsequent premium, if the insured shall furnish satisfactory proof that he has

been wholly disabled by bodily injuries or disease * * * the company * * * will agree to pay for the insured the premiums, if any, which shall thereafter become payable during the continuance of such disability."

In a well considered opinion the Court held that the disability having occurred, the insurance might be collected by his estate despite the fact that no proof of disability was given the company. Among other things, the Court said:

"In the case at bar Hazard's right to have the company pay his premiums was fixed, under the terms of the policy, at the time he became disabled, on June 25, 1910. He was not required to pay anything to have that right perfected, since by the terms of the policy all he had to do was to furnish proof of his disability. The right, therefore, having been fixed during the life of the policy, and without the payment of any further premiums, it is apparent, under the authority of the Montgomery Case, and the other cases heretofore cited, that time was not of the essence of Hazard's right to have the company pay his premiums. The presumption naturally arises that, having become totally disabled physically, he was not in a condition to attend to his business with that promptness which is required of persons in a normal condition. It is such conditions as these that give rise to the doctrine that time is not, in equity, of the essence of the contract. Since Hazard had the right at the time he became disabled, for the mere asking, to have the company pay his premiums until his death, we see no reason why, under the authorities heretofore cited, that he should not have had a reasonable time thereafter in which to present the

proofs of his disability as required by the policy. Under the facts of this case we are clearly of opinion that the proofs of disability were furnished within a reasonable time."

The second case cited by the Court in the Marshall case is *Merchants' Life Insurance Company v. Clark* (Tex. Civ. App.), 256 S. W. 969. The policy there involved provided for payments of monthly income and waiver of premiums in case of disability. The policy provided:

> "The first instalment of the above benefit will be paid immediately upon receipt of due and satisfactory proof of such total and permanent disability, or of any such injuries as above defined."

The insured became disabled by sickness and insanity while the policy was in force, which disability continued until his death, after default in the payment of premium. The Court said:

> "The insured being entitled, according to the finding of the jury, to demand payment of the instalments on making the proof, request, and waiver, the most appellant could contend for with reference to proof, etc., was that it be made within a reasonable time after the disability arose. The judgment involves a finding that the insured died before the expiration of such a time, and the policy provided that if the insured, being entitled to the instalments because of his disability, should die before all of same were made to him, the amount of the instalments not paid should be paid to appellee 'upon receipt of due proof of the death of the insured.'
>
> "On the case stated, we think it should be held (1)

> that the provision in the policy that appellant was to waive the payment of premiums while the insured was disabled, within the meaning of the policy operated, the insured being so disabled, to relieve him of the necessity of paying the premium in question within the time specified in the policy; (2) that the insured, because so disabled, was entitled at the time he died to demand of appellant payment of the annual instalments provided for in the policy, on making proof of such disability and request and waiver, as provided in the policy; (3) that the policy being, for the reasons stated, a valid obligation enforceable by the insured against appellant at the time he died, at his death became enforceable by appellee against appellant."

It is noticeable that in this connection the Court makes no distinction between the payments of disability income and the waiver of premium.

In *Missouri State Life Insurance Company v. Le Fevre* (Tex. Civ. App.), 10 S. W. (2d) 267, the policy contained provision for the waiver of premium in case the assured became totally and permanently disabled. The policy provided:

> "Disability benefits as provided on page 1 will be effective only upon receipt at the company's home office while no premium is in default, of due proof of existing total and permanent disability as hereinafter defined, providing such disability originated after this policy became effective and before its anniversary on which the insured's age at nearest birthday is 60 years, and will apply only to premiums falling due after receipt of such proof."

Other provisions as to a continuing disability for three months were almost identical with the language of the policies involved in the instant case. The insured became disabled from an attack of typhoid fever while the policy was in force. His illness continued until after default and the expiration of the grace period, resulting in his death. The Court said:

> "The contract for the disability benefit recites:
>
> " 'The annual premiums for the Total and permanent Disability benefits is 73 cents and is included in the premium stated in the consideration clause.'
>
> "Said contract also recites:
>
> " 'Premiums waived will not be deducted in any settlement under this policy.'
>
> "The effect of appellant's obligation to the assured, upon a sufficient consideration, was, if he became totally and permanently disabled, to allow him a sick benefit to the amount of the premiums thereafter accruing and in lieu of paying same to the assured, to apply same to the premiums accruing on his life insurance. The evident purpose of the disability provision was to preserve the insurance in the event the insured, on account of disability, became unable to make the money to pay the premiums, and said provision should be construed so as to effectuate this intention. So, where the insured was rendered incapable of furnishing proofs of disability by reason of such disability, then it must be presumed the parties did not intend by the language used to deprive the insured of the benefit he was to receive. We think the weight of authority is, and ought to be, that the stipulation as to the time within which notice or proof of disability should be given is

not necessarily to be literally complied with. Such provisions operate upon the contract only subsequent to the fact of the accident or sickness. Also, that where the failure to give prompt notice is not due to the negligence of the insured or his beneficiary, but such compliance has been prevented and rendered impossible from the nature of the situation, this would furnish a sufficient legal excuse for the delay in giving the stipulated notice; and this doctrine has been applied in cases in which a stipulated time for the giving of the notice or making the proof of disability has been fixed by the contract. * * * *

"We do not think the time of making the proof of disability was of the essence of the contract."

In *Metropolitan Life Insurance Company v. Carroll* (Ky.), 273 S. W. 54, the policy contained provisions for the waiver of premium in case the company received proof "after this policy has been in force one full year, and before default in the payment of any subsequent premium." During the grace period insured became disabled by disease and died a few days after the expiration of the grace period. Following the rule laid down in the Hazard case, the Court held that the beneficiary could collect the policy. The Court said:

"Before the days of grace expired and on July 15th, the insured was stricken with a mortal disease. He could not present proofs before he was taken sick, and it would be a very unreasonable construction of the contract to say that he lost his rights by not presenting proofs while in this condition and before his death on July 30th. Such a construction of the contract would

make it of no value to the insured in such cases, although this clause of the contract would, in many cases, be the inducement for taking the insurance, for this kind of insurance is usually taken by people who work for a living and who would rely on the company carrying the premium in case they become disabled.

"A very strict rule has been followed in favor of the insurer where the annual premium is not paid when due but this is for the reason that the annual premium is the basis of the contract and the business cannot be carried on without the payment of the premiums. But the furnishing of proofs of disability is entirely a different matter and it is a sound rule that time is not of the essence of the contract and that proofs may be furnished in a reasonable time. It would have been nugatory to furnish the proofs after the insured died and after the insurer denied liability on the contract. The denial of liability excused the furnishing of proofs then, and a reasonable time for furnishing the proofs had not then elapsed."

In *Fidelity Mutual Life Insurance Company v. Gardner's Administrator,* 233 Ky. 88, 25 S. W. (2d) 69, the policy provided for a waiver of premium and a disability income, provided proof of disability was received by the company "after the first premium shall have been paid hereunder and prior to default in payment of any subsequent premium, upon receipt by the company at its head office of due proof," etc. The first two years' premiums had been paid. The third premium became due and was unpaid. During the grace period the insured became ill, was sent to the hospital for operation and died subsequent

to the expiration of the grace period. The Hazard case and Carroll case, heretofore referred to, were relied upon by the Court, which held that the beneficiary of the insured can recover.

In *Bank of Commerce and Trust Company v. Northwestern National Life Insurance Company* (Tenn.), 26 S. W. (2d) 135, the policy contained provision for waiver of premium and payment of disability income in case the insured became totally and permanently disabled while the policy was in full force. The insured was taken ill with pneumonia during the grace period of the policy and died after the expiration of that period. The company contended that the provision for the waiver of premium did not become effective unless proof thereof was received prior to a default in the payment of premium The Court held, however, that the beneficiary could collect, following the decision of *Minnesota Mutual Life Insurance Company v. Marsall, supra.* The decision is based largely upon a construction of the policy, the Court pointing out that insofar as the company undertakes to insure against total disability, any provision seeking to limit the enforcement of the policy is repugnant to the undertaking and must therefore be strictly construed against the company.

In *Mid-Continent Life Insurance Company v. Hubbard* (Tex.), 32 S. W. (2d) 701, decided in November, 1930, the policy contained language almost identical with that here involved. The second annual premium became due and the company accepted a note payable in five months. Prior to the maturity of the note the insured was taken ill and remained totally disabled until his death, which occurred after

the note became due. The Court held that the beneficiary could recover, saying:

> "We think the construction insisted upon by appellant is unreasonable and contrary to the intention of the parties as manifested by a rational survey of the whole contract. Obviously, that intention was that in event the insured be injured or fall ill, and as a consequence unable to carry on his business or affairs, he would be relieved of the obligation to pay any premiums subsequently to become due, so long as he was incapacitated by his disability; that if he became incapacitated his income would cease, and his resources, if any, be required to sustain him in his illness; wherefore, his payment of insurance premiums should cease. Such was the obvious intention of the parties, gathered from the four corners of the contract. But when, at what juncture in the relation of the parties, should this suspension of payments begin? Should it operate upon the payment of the premium next due, or should it be postponed to the second such premium to become due? Obviously it was the intention that the moratorium begin at once upon the happening of the direful contingency which was to set it in operation; or, at most, within a reasonable time thereafter, since the requirement of prior proof of loss had been eliminated from the case. More obviously still was it the intention that the waiver should operate upon the annual premium next due, that it was not to pass around that premium and seize upon the second one to become due.
>
> "Appellant stresses the language of the waiver clause by which it is provided that in the contingency which happened here, then 'commencing with the anniver-

sary of the policy next succeeding the receipt of proof the company will on each anniversary waive payment of the premium for the ensuing insurance year.' Appellant argues very ably that the word 'anniversary' must be given controlling significance in construing this clause, and insists that the obligation to waive could not become operative until the next anniversary date of the policy, January 13, 1929, or upon any premium except that for the third year, which would have become due on said date. But we think that construction inconsistent with the obvious intention of the parties as disclosed by the contract, when viewed in the light of the case made here.

"For here, by express agreement, the premium for the second year did not mature prior to the date of insured's disability, or until three months thereafter, and under the terms of that agreement, as expressed in the blue note, 'all rights under the policy shall be the same as if the premium had been promptly paid when due.' In short, the insured became disabled while the policy was in full force and effect, and this contingency set in operation the waiver which, under a reasonable construction of the policy, was clearly intended to apply to all unpaid annual premiums not then due under the terms of the policy as modified by the solemn agreements of the parties to the contract."

That there is no difference between the construction of these policies with reference to the waiver of premium and the payment of disability income is demonstrated by *Intersouthern Life Insurance Company v. Hughes' Committee*, 6 S. W. (2d) 447, 224 Ky. 405. The policy provided that in case of total disability premiums would be

waived and an income paid. During the first year of the policy the insured became insane. Subsequently some settlement was made between the insured and the company, wherein the policy was surrendered to the company. In this action the committee for the insane assured was permitted to recover those instalments of disability income falling due during the term of the disability, it being held that the settlement and surrender of the policy might be disregarded because of the incompetency of the insured to make such settlement.

In *Levan v. Metropolitan Life Insurance Company,* 138 S. C. 253, 136 S. E. 304, the policy contained a provision for the waiver of premium in language practically identical with that contained in the policies under consideration. The insured became ill and was mentally deranged when the premium fell due. He was taken to the state hospital for the insane, where he died after the expiration of the grace period. A recovery was permitted upon the theory that the insanity of the insured excused his failure to notify the company of his disability, and that therefore his beneficiaries could recover upon the policy, despite the express provision that notice should be given "while the above numbered policy is in full force and effect and before default in the payment of any premium." It was held by the Court that the insanity of the assured excused the giving of notice, and that due to the fact that the assured was actually disabled during the time the policy was in force, the risk insured against had occurred, and that therefore the policy should be considered as being in full force at the time of his death.

In *McColgan v. New York Life Insurance Company,* 36

Ohio App. 123, 172 N. E. 849, policy was issued May 25, 1926. While the policy was in force, the insured became totally and permanently disabled by disease and died on July 9, 1927. The second annual premium was not paid and no notice of disability was given until October, 1927, after the assured's death. The policy contained provision for the waiver of premium, which appears to be practically identical with that here involved, it requiring that proof of disability be received before default in the payment of any premium. Judgment was rendered by the Trial Court in favor of the defendant upon plaintiff's opening statement, which judgment was reversed by the Appellate Court. The Court said:

> "By the plain and unambiguous words of the policy, it is kept in full force in event the insured is totally disabled on the due date of a premium, if such disability continues for a definite period of time and timely notice of such total disability is given to the company.
>
> "It being admitted by the defendant's motion that the insured was so disabled and that the defendant received notice of that fact within the period of time fixed by the policy, it follows that the judgment of the trial court was wrong."

In *State Life Insurance Company v. Fann* (Tex)., 269 S. W. 1111, policy was issued December 20, 1920. In December, 1921, notes were given to cover the second year's premium then due. Premium notes falling due June 20, 1922, remained unpaid. The insured became disabled by reason of insanity April 1, 1922, and remained in that condition until his death November 6, 1923. In August, 1922, the company notified the insured that the policy had lapsed

and sent him a check for an unearned portion of the premium note, which check was cashed and retained by the insured. The Court said:

> "At the time the premium note came due, and prior thereto, the insured had become insane. Did his failure to notify the company of his disability bar a recovery on the policy? We think not. The time for the payment of the premium having been extended by the company by the acceptance of the note of the insured, such extended time of payment cannot be considered as a matter of grace, but must be held to be a matter of right, based on contract. The insurance company did not, in accepting the insured's note, reserve the right to cancel the policy at any time it saw fit, pending the maturity of the note, but bound itself to extend the time of payment to the due date of the note. Of course, upon the failure to pay the premium note when due, such failure was equivalent to a failure to pay the premium, and would work a forfeiture of the policy (*Underwood v. Security Life & Annuity Co.,* 108 Tex. 381, 194 S. W. 585), except for the provisions of the disability clause above quoted. The Texarkana Court of Civil Appeals, in the case of *Merchants' Life Ins. Co. v. Clark*, 256 S. W. 969, holds:
>
> " 'It did not appear from the forfeiture clause, or any other part of the policy, that the proof, request, and waiver referred to must have been made before the expiration of the 31 days specified. On the contrary, the time within which the insured was to make such proof, etc., was not limited by anything in the policy.'
>
> "And further held:
>
> " '(1) That the provision in the policy that appel-

lant was to waive the payment of premiums while the insured was disabled, within the meaning of the policy, operated, the insured being so disabled, to relieve him of the necessity of paying the premium in question within the time specified in the policy.'

"Under the authority of this case, the Supreme Court having refused an application for writ of error, we hold that the life insurance policy sued on in this case was not forfeited by the failure of the insured to pay the premium note in question, or to notify the company of his disability."

In *Hagman v. Equitable Life Assurance Society,* 214 Ky. 56, 282 S. W. 1112, the policy contained a provision that the payments for disability should be payable six months after receipt of proofs of such total and permanent disability and monthly thereafter during the continuance of such total and permanent disability. The excuse given for failure to give notice as required by the policy was that the policy itself was in the possession of the company by reason of a loan having been given to the assured. In construing the provision of the policy, the Court said:

"The clause providing that the income shall be payable six months after receiving such proof, and monthly thereafter, does not provide that only one monthly payment is to be made then. To so construe the contract would make it a contract to pay the annual income after eight months of total disability. That cannot be the meaning of the contract; it provides that the total disability shall be presumed to be permanent when it is present and has existed continuously for three months. The purpose of postponing pay day was to give the

company an opportunity to investigate the facts. The provision that the payments are to be made monthly *thereafter* indicates that a monthly payment then was not contemplated. The purpose of such a provision is to provide the insured with an income in case of total disability, and the natural meaning of the contract is that this income will begin after the total disability has continued sixty days and he furnishes proof thereof. The right to relief from the payment of premium and the right to an annual income of $2,400 accrue at the same time. The insured would not understand when he took this policy, and it was not intended that he should understand, that these rights did not accrue until total disability had existed for eight months."

This case has heretofore been referred to as illustrative of what constitutes total disability.

In *Aetna Life Insurance Company v. Palmer,* 159 Ga. 371, 125 S. E. 829, the question was certified to the Supreme Court whether under a policy similar to that here involved and disability of the assured occurring while the policy was in force, the failure to notify the company of the disability prior to default and expiration of the grace period prevented a recovery of monthly disability income. In a well considered opinion the Court held that the giving of such notice prior to such default was not a condition precedent.

It will be seen from the foregoing authorities that the question here involved has been dealt with by the Court from several different angles. The sum and substance of these rulings appears to be that the provision of the policy for giving of notice prior to default is not an integral part of

the contract of insurance, and that in case of disability occurring while the policy is in force, a failure to give notice may be excused. Inability to give notice certainly is an excuse, and where the assured does not know that the disability from which he is then suffering is permanent in character, the giving of such notice would be a physical impossibility.

As the facts are now established, at the time the annual premiums became due on these policies, facts existed which excused their payment. The express contract of the company was to keep the policies in force without further payment. As the facts then existed, the plaintiff owed the company nothing. On the contrary, the company owed the plaitiff for several months' disability income. The notes given for premiums for the second year were therefore actually without consideration, they represented no obligation to the insurance company, and their surrender constituted no consideration. The entire transaction of the surrender of these policies was entered into by a mutual mistake of fact.

A case very similar in principle is *Hawthorne v. Travelers' Protective Association,* 112 Kan. 356, 210 Pac. 1086, 29 A. L. R. 494. This case involved an accident policy providing for the payment of income during the period of disability occasioned by accident. The policy expressly provided that there should be no liability unless the assured should immediately notify the insurer of any disabling injury. The policy provided that such notice must be given within thirty days of the time of the accident and that "in case of failure to notify, except because of unconsciousness or physical disability, the member or his beneficiary in case

of death, shall forfeit all rights to insurance benefits." In April, 1913, the insured was nailing wire netting to his porch, standing upon an upturned candy bucket and holding a fence staple in his mouth. The bucket collapsed, causing the insured to fall, and the staple disappeared. Thinking that perhaps the staple had gone down his throat, he consulted physicians, but they assured him that he was mistaken. As a matter of fact, he had swallowed the staple, but did not learn of such fact until it was revealed lodged in his throat by an X-ray examination early in 1915. In the meantime he had suffered disability but believed it was due to other causes and not to an accident, within the meaning of the policy. The Court, in a well considered opinion, held that his ignorance of the accidental cause of his disability excused the notice, which was actually given within a reasonable time after the staple was removed from his throat. Action was brought on the policy in April, 1920, and within the time limited for commencement of actions upon written contracts. The Court said:

> "That the modern tendency is to hold insurers to a more strict accountability is undoubted. Those who disapprove the process often characterize it as making a new contract for the parties. We think it may fairly be called interpreting the contract in the light of the general purpose for which it was entered into, and of the consideration that the obvious purpose of an insurance policy is to insure. The language employed in an insurance policy may properly be limited in its application to the situation to which it is adapted, and which it presumably was intended to meet. We do not undertake to say that a valid insurance contract could not be drawn providing for a forfeiture of the right to

> indemnity if the insured should fail to give notice of something that he did not know had taken place. But a purpose to impose a condition so impossible of performance ought not to be attributed to the parties, unless evidenced by express and unmistakable language, as, for instance, by saying that ignorance of the fact should not excuse a delay. In the present case the inference that because two exceptions to the rule requiring notice at the time of injury are expressed—unconsciousness and physical disability—it was not intended that want of knowledge should be implied may well give way to the presumption that only a fair and reasonable requirement was intended."

The following miscellaneous cases throw additional light upon the failure to pay subsequent premiums:

In *Newman v. John Hancock Mutual Life Insurance Company,* 216 Mo. App. 180, 7 S. W. (2d) 1015, it was held that where premium was refused by the insurer under the mistaken theory that the policy was in default, the insured was not required to tender payment of further premiums in order to preserve his rights under the original policy.

In *Inter-Southern Life Insurance Company v. Duff,* 184 Ky. 227, 211 S. W. 738, it was held that the insured was relieved of tendering subsequent premiums, where the company had wrongfully refused to accept the premiums.

In *Security Life Insurance Company v. Gottman* (Ind. App.), 156 N. E. 173, it was held that further performance on the part of the insured was excused where the policy was wrongfully declared to be forfeited by the company.

In *Spencer v. Security Benefit Association* (Mo. App.), 297 S. W. 989, it was held that the insured was not required to pay subsequent premiums after the insurer wrongfully attempted to forfeit the policy.

An interesting case in this connection is *Frommelt v. Travelers' Insurance Company,* 150 Minn. 66, 184 N. W. 565. In this case it was sought to excuse failure to give notice of loss as provided by the terms of the policy. It appeared that shortly after the time of the death of insured an agent of the company had taken up the policy and had given to the beneficiary certain money which it was claimed was a refund of a portion of the premium. It was held that the failure to give notice was properly excused. The Court said:

> "The requirement of immediate notice is a requirement of notice within a reasonable time, and what is a reasonable time depends on the circumstances of the particular case. *C. S. Brackett & Co. v. General Accident F. & L. Assur. Corp.* 140 Minn. 271, 167 N. W. 798. The fact that the poicy was not in the possession of plaintiff, but of the company, is important (*Curran v. National Life Ins. Co.,* 251 Pa. St. 420, 96 Atl. 1041; *Solomon v. Continental Fire Ins. Co.,* 160 N. Y. 595, 55 N. E. 279, 46 L. R. A. 682, 73 Am. St. Rep. 707), for plaintiff could have no knowledge of its terms, and, without disparagement of her case, it may well be said that she probably did not realize at once that her husband's death was due to accident. Under such circumstances, we think the delay of plaintiff was excused." (Page 566.)

Two other cases may be of more than passing interest to

the Court. In *Shafer v. United States Casualty Company,* 156 Pac. 861, 90 Wash. 687, it was held that the failure to give to the insurer notice of an accident within the time provided by the policy was excused where the insured did not know that the accident had happened. There the insurance covered liability of the insured growing out of any accidental injury in and about the operation of a certain building. An accident occurred, but the assured knew nothing of it. It was held, therefore, that they could not be required to give to the company notice of something which was unknown ot them.

In *Houseman v. Home Insurance Company* 88 S. E. 1048, 78 W. Va. 203, L. R. A. 1917-A 299, it was held that insanity of the insured was a sufficient excuse for the failure to give notice as provided by the policy. In this connection we again ask the Court to bear in mind that we are not here concerned with the failure to pay a premium but are concerned only with the failure to give the notice of the happening of a permanent disability which automatically continued the policies in force without payment of premium.

It is true, of course, that there was considerable delay before plaintiff's claim was actually made. Under the foregoing authorities this delay is amply excused. After the transactions relative to the surrender of the policies in 1927 the plaintiff did not have these policies in his possession. As shown by the evidence, he firmly believed that the entire transaction was at an end. Several months elapsed before he discovered the nature of his ailment and it was not until the latter part of that year that he discovered that his ailment had extended back to July, 1926, and that he had then been afflicted with tuberculosis. It was not until demand

was made upon him for the payment of the note for $339.39, at which time he was informed that he had had the benefit of insurance during 1926 and should therefore pay for it, that he realized for the first time that during that period the risk against which he carried insurance had occurred, and that he was required to pay for insurance against that very risk. He thereupon promptly made claim, payment of which was refused. It is interesting to note that after this controversy arose he was compelled to pay for the insurance. (T. 175.) Yet defendant takes the position that although entitled to payment for issuing the insurance and although the risk insured against occurred, it is relieved from the terms of its contract because appellant failed to give prompt notice, when the giving of such notice was rendered impossible because of his ignorance of the facts. We submit that such failure is completely excused by the facts shown by the undisputed testimony.

IV

The Attempted Cancellation and Surrender of the Policies was Ineffectual

Little need be added relative to this feature of the controversy. It is true that by the series of transactions occurring in the early part of 1927 the policies were surrendered and premiums were collected from the plaintiff for insurance up to and including March 18, 1927. This fact, however, furnishes no defense whatever. This is an equitable proceeding and the Court has entire power to and must disregard these releases when made under a mistake of fact and when not supported by any consideration. It must be conceded by the respondent that at the time of these transactions it was believed both by the insured and the insurer

that premiums for the second year's insurance were due and payable. Both parties to the transaction thought that no risk insured against had occurred. Both parties were ignorant of the true nature of plaintiff's disability. Both parties believed that the plaintiff owed the defendant money for premiums. Neither party realized that the risk insured against had occurred, and that as a result of the happening thereof no premiums were payable. In each of the three policies express provision is contained whereby for a certain named premium the company agrees to carry the insurance in force for the period of the disability without further premium. There was therefore nothing actually due from the plaintiff to the defendant. On the contrary, by the additional provisions contained in the policies for $10,000.00 and $15,000.00, respectively, the defendant was obligated to the plaintiff for the sum of $250.00 per month during disability, a period of something over seven months. The fact was that unknown to the parties, the defendant was then obligated to pay to the plaintiff something more than $1,800.00. We submit that no clearer case of lack of consideration and mutual mistake can be imagined. We need no further authority, therefore, for the proposition that these releases or surrenders of the policies were ineffectual and furnish no defense whatever.

All of the findings of the trial Court with reference to the surrender of these policies and of laches on the part of the plaintiff in making his claim against the company are predicated upon the express finding and theory that the plaintiff was not disabled during the term of the policy. If that finding falls, all other findings must fall with it. If that finding falls, a new trial is necessary. On the contrary,

if that finding is sustained, it ends the case and it is unnecessary to consider any of the other features.

In Conclusion

We respectfully submit that the adverse findings of the trial Court were contrary to the evidence, and that the plaintiff is entitled to a new trial. It is entirely possible that upon a new trial the Court may feel that to do complete equity to the parties some adjustment may be necessary in the amount of the plaintiff's recovery to cover all possible contingencies of interest, dividends and similar matters in connection therewith. It may be possible that some equitable adjustment should be made to adjust premiums which should have been paid in the absence of the surrender of the policies. Those questions, however, are details which can properly be taken care of in fixing the amount of recovery.

We respectfully submit that the judgment herein should be reversed.

Respectfully submitted,

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